MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Friday, April 26, 2002
9:00 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
ALICE ROSENBLATT
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: State-level variations in Medicare spending: preliminary observations -- David Glass, Dan Zabinski

MR. GLASS: This is a look at some preliminary analysis that we've done. It's kind of a heads up for everybody on what we've been talking to Congress about.

First of all, why is geographic variation of interest? Well, it's politically important because it's a question of equity in the eyes of those in Congress. They look at it and if their state is way at the bottom, they say why is that? That's what we're going to talk about first in this.

It also, of course, determines M+C payments under our Commission recommendation. And it may help us understand appropriate resource use and maybe even how quality affects resource use.

I realize no one can read this from the slide, but I hope you all have it in front of you. The point of it is there's a somewhat peculiar measure that's commonly used when talking about spending per state. These numbers that you see here appear in something called the Green Book that the Ways and Means Committee publishes, and CMS publishes them. The Kaiser Family Foundation actually put these out.

The reason people are concerned about it, of course, is that if you happen to live in Iowa and you realize that you're under 60 percent of the national average, and you look at people in D.C. and they seem to be over 180 percent of the national average, you say this isn't fair.

So these numbers raise a tremendous amount of concern in Congress. We think, though, that it's a very peculiar measure and one that probably shouldn't be used because it's misleading.

Basically, the reason it's misleading is what these numbers are is they're taking the total amount of Medicare dollars spent in the state that providers receive in payments in a state, and dividing it by the number of beneficiaries in a state. What that doesn't account for is beneficiaries who go outside of the state to use health care services.

So in Iowa, if a lot of people in Northern Iowa go up to the Mayo Clinic in Minnesota, just across the border, that depresses this number for Iowa. In the District of Columbia, where we are now, lots of people from Maryland come in and use doctors and hospitals in D.C. So you get a tremendously large number showing up in D.C.

But the point is it really doesn't have anything to do with the number of beneficiaries in D.C. It's the number of beneficiaries using health services in D.C. So this is not a very helpful number to use, and it's fairly easy to correct, and the next one shows that.

In this chart, we've corrected for this migration question. This is what we call a better measure. This is spending on behalf of fee-for-service beneficiaries, not just spending in a state. So this actually traces the spending back to the beneficiary and his state of residence.

Now we see that Iowa is suddenly not under 60 percent, but

up closer to 80 percent. And D.C. has dropped down to a little under 140 percent. So there's still some variation but you can see that it's much more compressed than it was in the previous example. This would just be a better measure to use.

This is looking at spending numbers so it includes all the GME and the DSH payments to hospitals and it includes the cost-of-living differences between states and all that sort of thing. And of course, it doesn't adjust for health status, that maybe you have healthier beneficiaries in some states and sicker beneficiaries in another.

So in the next slide, we've done all that. And we've come up with a measure that we call service use per beneficiary. Here you can see the variation has been compressed even more. Iowa is now just a little bit under average, as it turns out as the District of Columbia. So we've now managed to crunch those down very much and there are a couple of oddities here. Hawaii is way under and we see a couple of states, like Louisiana and Mississippi, are pretty far over.

So this is a measure of service use, we've adjusted for health status using, in fact, the HCC risk adjuster that we've just talked about. We used the full model, the whole HCC. So this is taken account of health status and we've taken out all of the geographic costs of living and that sort of thing, the adjusters.

Now another view of this same data is shown on the next slide, where light is less, dark is more. Hawaii is not on here, but it was light. You can see that curiously, the dark states all seem to be down around the Gulf of Mexico and stretching up through Appalachia. One could conclude, I guess, various things from here. One is that our risk adjuster doesn't account for some demographic things that are also affecting service use. Maybe some places have lower health care quality and therefore have more use because they don't get well the first time they go in. Or maybe service use is a good thing. I don't know.

But this raises many questions. But the point is that it's a very different picture from the first one we started with, which got people very excited about inequity in the system.

So depending on how you look at equity in the system, you get very different answers.

So let us quickly move beyond this to the last slide and talk about some possible next steps. This is kind of an issue probably for the retreat, do we want to pursue this kind of questioning and analysis? We can certainly refine the current analysis. We can look at some of the distribution, rather than just the average. Because an interesting question, whether -- the average is about 20 percent of people go to the hospital. They use a lot of spending.

Is it that in some states that number is 25 percent and in some states it's 15 percent? Or is it that in some states the entire distribution has moved up and everyone in that state just uses more services than a similarly situated person in another state. So we'd kind of like to do some of that distributional analysis to understand what this looks like.

We also want to consider what geographic area is most

relevant. We've been looking at a state level variation. Some people would say well, that's ridiculous even to look at because it's too big an area and it's not very meaningful. But Congress thinks it's very meaningful.

County is used on the M+C world and we don't particularly like counties. I'm not sure anyone does, but that's another possibility. Metropolitan statistical area is another one. Hospital markets are a very interesting one and Wennberg and the Dartmouth Atlas people have defined several of those. We used a definition of those in our last June report.

The curious thing about that is the Wennberg analysis shows that you get really high use where there are a lot of specialists. But if you look at the state level, I mean it's not obvious to me there are a lot more specialists in Louisiana than New York, but I don't know.

Anyway, what level we look at is interesting and it might just depend on what question we're trying to answer. And we might want to look at all of these areas and all of these levels and compare. But the question is do we want to pursue this line of analysis? And we can bring it up at the retreat.

DR. ROSS: I just want to reiterate what David started out with, the motivation for bringing this to you, is that first measure that we've called a peculiar measure has been generating a lot of -- I don't know if it's heat or light or something up on the Hill. And since it's sort of fundamentally an odd thing to look at, we thought at a minimum we wanted to get some information to you to look at this a little bit differently. But honestly, it's not clear where you go next on this and that's where we'd like whatever feedback you can offer.

MR. HACKBARTH: The graph, a measure of service use per beneficiary, that's the analysis that we did for the rural report basically?

MR. GLASS: Right, that's the June report added up by state instead of county.

MR. HACKBARTH: So there are two distinct questions here. One is is my state or my Congressional district getting its fair share of the dollars? A second question, and the one we were trying to address in the rural report, is are people getting access to care?

This one, a measure of service use, is not about dollars but about service use. So to the extent that people are concerned about the wage index adjustments and the teaching payments, et cetera, that doesn't show up here but rather on the preceding graph that has the dollars allocated appropriately to jurisdictions. So there really are two distinct questions.

MR. GLASS: That's correct.

DR. WAKEFIELD: I just wanted to affirm that. Actually, I was asking Alan before the very same question, Glenn. What's reflected in the service use graphs, separate from the actual costs or the price of providing services in those different states. So what does the payment side of this look like? Because I think if you just show them service use, that's a part of the answer to the question but it's only a part of it, it seems to me.

MR. HACKBARTH: The payments are totally captured in the preceding graph that has the dollars per beneficiary properly allocated to the states.

MR. GLASS: Right, and we presented both because it's a question of what do you look upon as equity.

DR. REISCHAUER: I would say that we've gone about as far as we should go into this area because this is a slippery slope that gets you quickly into some real political difficulties, where we really can't shed a lot of light on the underlying relationships and where there will be superficial claims of inequity.

We don't have the relative age distribution or the health status adjustment here, do we?

DR. WAKEFIELD: Yes, you do.

MR. GLASS: The service use actually does that.

DR. REISCHAUER: But my guess is that's a tough one to do. There's the issue of taste for medical care and there is a distinction between the Norwegian bachelor farmer in Minnesota and the hypochondriacs in New York. Carol's gone? Good.

MS. RAPHAEL: I heard that.

DR. REISCHAUER: It's like a bad opera, from the wings a voice comes.

[Laughter.]

MR. GLASS: Though interestingly enough, if you look at service use, New York is actually less than Minnesota.

DR. REISCHAUER: Upstate. They don't have access. But then let's say there is a perceived inequity on one side of the balance sheet here, which I'm not sure we could ever show or would want to show. There's a whole other side to this equation, which is who's footing the bill, which another group will come up with.

I just think this is interesting. We've enlightened or cleared away some misunderstanding. Stop.

DR. NELSON: Bob, do you recommend that as far as we've gone that we share in a report?

DR. REISCHAUER: We've already shared it, in one sense.

DR. ROSS: It's being shared.

MR. FEEZOR: My one suggestion, if you're going to use the map, we probably ought to include all 50 states.

DR. REISCHAUER: Judging from this, Hawaii is probably under the water.

MR. HACKBARTH: Can I just ask one question? We have the letter from Senator Harkin. How are we responding to the specific requests here? I think we've answered them all.

DR. ROSS: We'll respond to that at the staff level, but that's a follow-up to a request in an appropriations bill a year ago for information on this, which we've mostly been handling at a staff level because this is just technical information. There's no policy recommendations that drop out of it immediately.

MS. ROSENBLATT: I probably agree with Bob but I want to offer a contrarian view anyway, because looking at the risk adjusted graph and seeing the numbers, my intellectual curiosity is still aroused as to why are we getting those differences. If we wanted to go down that path, what I would want to do is I

would want to look at it by hospital area. What did you call it, hospital market area.

And I would want to look at it totally desegregated. I'd want to look at what's inpatient use versus cost. So I think the actuary in me is seeing all these things and saying this is pretty interesting, but I don't know that it would lead to any conclusions that would be beneficial. So that's where I agree with Bob.

MR. SMITH: I think we should restrain our intellectual curiosity. I had some of the same reactions, but I think Bob's call for --

MR. HACKBARTH: And there are other institutions that can do the intellectual analysis. We don't need to put ourselves in the middle of that.

I think we've covered this topic for now. Interesting.